



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

KUNJEELAL CHANDRAKAR

**Respondent Name**

AMERICAN ZURICH INSURANCE CO

**MFDR Tracking Number**

M4-13-0959-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

December 14, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Please accept the following Position Statement as required by Rule 133.307 (C)(2)(f).

**(F) a position statement of the disputed issue(s) that shall include:**

**(i) a description of the health care for which payment is in dispute,**

DESIGNATED DOCTOR EXAM

**(ii) the requestor's reasoning for why the disputed fee should be paid or refunded,**

CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS"

**Amount in Dispute:** \$150.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** Carrier did not respond to the requestor's DWC-60 submission.

**Response Submitted by:** na

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2012	CPT Code 99456-WP-W5	\$150.00	\$150.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1 – Workers' Compensation Jurisdictional fee schedule adjustment

## **Issues**

1. Is CPT Code 99456-WP-W5 supported?
2. Is the requestor entitled to reimbursement?

## **Findings**

1. Per 28 Texas Administrative Code §134.204 states (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:
  - (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:
    - (A) the examination;
    - (B) consultation with the injured employee;
    - (C) review of the records and films;
  - (C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection.
  - (3) The following applies for billing and reimbursement of an MMI evaluation.
    - (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.
  - (4) The following applies for billing and reimbursement of an IR evaluation.
    - (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.
    - (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
      - (i) Musculoskeletal body areas are defined as follows:
        - (I) spine and pelvis;
        - (II) upper extremities and hands; and,
        - (III) lower extremities (including feet).
      - (ii) The MAR for musculoskeletal body areas shall be as follows.
        - (II) If full physical evaluation, with range of motion, is performed:
          - (-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area.
        - (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.
  2. The respondent issued payment in the amount of \$350.00. Based upon the documentation submitted and the *Table of Disputed Services*, additional reimbursement in the amount of \$150.00 is recommended.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

6/18/14  
\_\_\_\_\_  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**